COMMUNITY MINI-GRANT APPLICATION

(Please type or print)

Applicant Name: _____

Contact Person: _____

Mailing/Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Proposed Service Area (Census Tracts, Cities, Counties): _____

_____

Estimated Population of Service Area: _____

Projected Number of Patients (Recommended - Minimum of 4,500): _____

Projected Number of Visits: _____

Please Check ONE on each line:

1.) ❑ Private Nonprofit ❑ Public Entity ❑ Tribal

2.) ❑ Urban ❑ Rural ❑ Sparsely Populated/Frontier (less than 7 persons per square mile - see attached map)

3.) Is the area designated as Medically Underserved Area (MUA - see attached map) or Medically Underserved Population (MUP)? ❑ Yes ❑ No ❑ Unsure

4.) Is the area designated as a Health Professional Shortage Area (HPSA)?
❑ Yes ❑ No ❑ Unsure

5.) Will the proposed health center be:
❑ A new health center
❑ A new site as an expansion off of an existing health center
❑ A medical capacity expansion or service expansion of an existing center

Please check all that apply:

❑ Tribal Entity ❑ Faith-based Organization ❑ Public Health Department ❑ Hospital

❑ University ❑ Local Government ❑ Primary Care Clinic ❑ Rural Health Clinic

❑ Other _____

TARGET POPULATION CHARACTERISTICS

	CHARACTERISTIC	TARGET POPULATION DATA (Use 2000 Census)	
		Number	Percent
AGE	0-14		
	15-44		
	45-64		
	65 and older		
RACE/ETHNICITY	White (non-Hispanic)		
	Black or African-American (non-Hispanic)		
	Hispanic		
	American Indian or Alaskan Native		
	Asian		
	Native Hawaiian or Other Pacific Islander		
	Other		
	Total Population		
INCOME AS A PERCENT OF POVERTY LEVEL	Below 100%		
	100-199 percent		
	200 percent and above		
	Unknown		
OTHER	Uninsured - Source:		

List other providers of care (primary care, dental, behavioral health, hospitals, etc.) in the service area:

What are the issues creating a high need for primary health services for the target population, including any significant or unique barriers to care (please use Census 2000 or more recent data for any relative statistical information):

Health Disparities (High incidence of alcohol abuse, asthma, cancer, heart disease, diabetes, drug abuse, dental caries, hypertension, infant mortality, low birth weight, obesity, suicide, teen pregnancy, etc.)

General Barriers (Distance to other providers, lack of public transportation, need for translation services, cultural differences, local physicians are unwilling to accept new Medicaid patients, high percentage of elderly, high rate of unemployment, etc.)

How will you provide the following services? If services will be contracted or provided by referral, list the name of the provider, if known:

Service Type	Direct Service	Contractual Arrangement	Referral
Primary Care			
Mental Health			
Substance Abuse			
Oral Health Services			
X-ray/Lab Services			
Pharmacy			
Other			

What steps has the applicant taken in applying for health center funding?

Have community meetings been held regarding health care access? If yes, list: (a) Meeting dates; (b) Number in attendance; (c) Agencies/groups/government officials represented; (d) Representation by potential health center patients; (e) meeting outcomes.

Have you contacted the PCA (Community HealthCare Association of the Dakotas) or PCO (State Health Department) about your interest in community health centers? If yes, please provide the name of the entity and person you contacted.

Board members (user, non-user, background in health care, which community do they represent) – Please feel free to add an additional sheet if needed.

Name of Board Member	Potential Patient (Yes/No)	Area of Expertise	Community or Population Represented

Business Plan / Proposed Budget

1. Provide brief discussion of projected use of funds and comment on how any non-grant funds may be used to leverage the proposal. (Grant dollars should equal $150 per patient per year unless otherwise justified.) Proposed Total Operating Budget for Health Center Grant $_____

2. Capital needs. Please itemize if applicable (Grant funds are limited to no more than $150,000 for one-time capital costs in year one only)
   $_____

3. Amount of Federal funds sought (Recommended guideline is $150 federal grant dollars per patient per year) $_____

Capacity / readiness (Include an address and description such as number of possible exam rooms, anticipated rent, equipment, on-site lab/x-ray, proximity to public transportation, etc.)

Providers (Name and type of provider - physicians, mid-levels, medical director)

Staff (Management, clinical, other)

One-page narrative

1. how state grant dollars will be spent;
2. a brief description of the entity's immediate readiness should federal grant funds be awarded;
3. a brief description of the entity's five year goals should federal grant funds be awarded

Attachments: Frontier map
MUA/MUP map

Application must be received by 5:00 P.M. on Friday, January 30, 2003. Application can be mail to: Tom Solberg, Medical Services Division, Department of Human Services, 600E Boulevard Ave Dept 325, Bismarck ND 58505-0261. Application can be electronically submitted to Tom Solberg at sosolt@state.nd.us